

EXHIBIT 11

In the Matter of:

Jonathan R., et al.,

vs

JIM JUSTICE, et al.

CYNTHIA PARSONS

June 27, 2024



5010 Dempsey Drive
Cross Lanes WV 25313
304-415-1122

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

JONATHAN R., minor, by Next Friend, Sarah
DIXON, et al.,

Plaintiffs,

-vs- Case No. 3:19-cv-00710

JIM JUSTICE, in his official capacity as
Governor of West Virginia, et al.,

Defendants.

DEPOSITION OF CYNTHIA PARSONS

The deposition of Cynthia Parsons was
taken on June 27, 2024, at 8:56 a.m.,
at 2116 Kanawha Boulevard, East, Charleston,
West Virginia.

ELITE COURT REPORTING, LLC
5010 Dempsey Drive
Cross Lanes, West Virginia 25313
(304) 415-1122

Tara Arthur, CCR

A P P E A R A N C E S

Rich W. Walters
J. Alex Meade
Attorneys at Law
Shaffer & Shaffer, PLLC
P.O. Box 3973
Charleston, West Virginia 25339-3973

Julia Siegenberg
Kendra Doty
Attorneys at Law
Brown & Peisch, PLLC
1233 20th Street NW, Suite 505
Washington, DC 20001

Also Present: Cammie Chapman, Esq.
Steve Compton - Via Zoom

1 I N D E X

2 WITNESS

3 Cynthia Parsons

4 EXAMINATION

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16 Reporter's Certificate: Page 88

Errata Sheet/Signature Page: Enclosed

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1 CYNTHIA PARSONS,
2 called as a witness, first being duly sworn
3 by the Court Reporter/Notary Public,
4 testified as follows, to wit:

5 EXAMINATION

6 BY MR. WALTERS:

7 Q. Ms. Parsons, could you please state
8 your full name?

9 A. Cynthia Ann Hammock Parsons.

10 Q. Ms. Parsons, where are you
11 currently employed?

12 A. West Virginia Department of Human
13 Services, the Bureau for Medical Services.

14 Q. BMS?

15 A. Uh-huh.

16 Q. Do you still call it DHHR?

17 A. No. The name got changed.

18 Q. I know that. But do you still call
19 it DHHR?

20 A. We practice -- we practice saying
21 it correctly.

22 Q. Okay. Don't hold it against me if
23 I call it DHHR.

24 A. That's okay.

1 Q. And I'm sorry. What's your
2 position with BMS?

3 A. I'm the director of behavioral
4 health and long-term care services.

5 Q. Okay. And how long have you been
6 in that position?

7 A. That particular position would be
8 four years now.

9 Q. All right. Before we get started,
10 have you had your deposition taken before?

11 A. Years ago, yes. I used to be a
12 therapist, yeah.

13 Q. Oh, okay. So you've been through
14 it multiple times?

15 A. It has been a few years. Yeah, it
16 has been about 16 years ago.

17 Q. Let me go through a couple of the
18 ground rules you already know. But let me
19 state them anyway. Obviously, I am going to
20 be asking you questions. You are going to
21 be giving me answers. Make sure that I
22 finish asking my question before you start
23 talking even though you know what I'm going
24 to say. Our court reporter can only take

1 down one of us at a time, so we try not to
2 talk over each other. Otherwise, she starts
3 kicking me.

4 If I ask you a question that you
5 don't understand, or when I ask you a
6 question that doesn't make sense, please ask
7 me to repeat it. Make sure we are clear and
8 on the same page, and we understand you are
9 answering the same question I am asking.

10 I don't expect this to be a very
11 long deposition. But if you need -- we are
12 on Zoom as well. I keep forgetting that. I
13 don't expect it to be a long depo. But if
14 you need a break, let us know. I will be
15 happy to accommodate you. And if you have
16 any questions, by all means, let me know.

17 What did you do to prepare for your
18 deposition here today?

19 A. I worked with Kendra and Julia.
20 And we had probably 20 hours' worth of
21 speaking.

22 Q. Okay. And as part of being a
23 30(b)(6) deposition, did you do any type of
24 investigation or research into the topics

1 other than discussions with the attorneys?

2 A. No.

3 Q. The main thing that -- I mean,
4 obviously, the topic here is actions taken
5 to increase number of type, availability of
6 community-based services, including wrap-
7 around services.

8 A. Uh-huh.

9 Q. So tell me, generally speaking,
10 what has DoHS done to increase the number
11 and type of availability of community-based
12 or wrap-around services?

13 MS. DOTY: Objection. Outside
14 of the scope. We have agreed that
15 Ms. Parsons is being designated to speak
16 only with respect to Medicaid-covered
17 services.

18 MR. WALTERS: Right. And that's
19 fair.

20 Q. And I am asking you with regard and
21 in the scope of Medicaid-offered services.

22 A. One of the first things we did was
23 expand ACT Services. So individuals 18 to
24 21, which is still under the child age limit

1 -- we gained two providers. That included
2 Northwood and Eastridge.

3 We also worked on increasing
4 reimbursement rates for behavioral health
5 community-based services for 5 percent
6 total. We were able to take a pilot program
7 -- which is Mobile Crisis Services for
8 Children. And we did the sustainability
9 plan and got a state plan amendment approved
10 by CMS for us to reimburse for that service.

11 We also included the CSED Waiver.
12 So CSED Waiver is a community-based program
13 that we got approved also through a 1915(c)
14 through CMS for children up to the age of
15 21. And there was also a CHIP
16 implementation plan -- which I was not a
17 part of that. But there is a CHIP
18 implementation plan.

19 Q. With regard to the ACT Services,
20 how many children -- when was that
21 implemented?

22 A. ACT itself has been around since
23 about 2008. So it has been existing since
24 then. We have had a state plan amendment

1 approved since then. We have always allowed
2 18 to 21-year-olds to be a part of that
3 program. We just expanded to two more
4 providers to ensure statewide coverage.

5 Q. Okay. And those two providers were
6 in the northern part of the state?

7 A. Northwood, Northern Panhandle.
8 And Eastridge is the Eastern Panhandle.

9 Q. When were those two providers
10 added?

11 A. I think 2022.

12 Q. Do you know as of today how many
13 foster care -- or children in DoHS custody
14 are currently receiving services through
15 ACT?

16 A. I do not know the total number.

17 Q. Do we know whether or not adding
18 those providers increased the number of
19 children being provided services through
20 ACT?

21 A. It would have provided access. So
22 you have to meet admission criteria. So if
23 certain individuals in that age group met
24 admission criteria, then they would be able

1 to get the service in those areas.

2 Q. So as part of expanding those
3 services, you added providers. But we don't
4 -- DoHS doesn't know whether or not adding
5 those providers actually increased the
6 amount of individuals actually receiving
7 services; is that fair?

8 A. I don't know that number today.

9 Q. And when was the CSED Waiver
10 Program created?

11 A. We were approved in 2020.

12 Q. What is the purpose of the CSED
13 Waiver Program?

14 A. So CSED Waiver is a program
15 developed to ensure that children could stay
16 in their community and receive wraparound
17 services and other services. It's to ensure
18 that there's access at the community level
19 so they don't have to go to residential or
20 facility-based care.

21 Q. You say access to facility level to
22 make sure they don't have to go into
23 residential care. Does it also provide
24 services to individuals on wait lists or

1 waiting to receive residential care
2 services?

3 A. Yes. We have interim services.

4 But again, the total goal is to ensure they
5 stay in the community. It is not really
6 used as a fail-safe to hold till they get in
7 residential care. It can be. But the whole
8 point is -- we feel like we could integrate
9 services while they are living at home with
10 the family and the community so they never
11 have to go to facility-based care.

12 Q. Okay. And are you aware of the
13 wait lists associated with the CSED Waiver
14 Program?

15 A. I do have a wait list. CSED Waiver
16 as of June 14th was 30.

17 Q. And what efforts, if any, are DoHS
18 taking to reduce the wait list?

19 MS. DOTY: Objection. Vague.

20 Q. Go ahead. Yeah. When she objects,
21 you can go ahead and answer unless she
22 instructs you not to answer. When she does
23 that, that means I asked a really bad
24 question.

1 A. We also have other services through
2 Medicaid that they can receive. So you
3 still have therapies you could receive from
4 licensed behavioral health centers. You
5 have QHCs, licensed independent medical
6 social workers, LPCs, and licensed
7 psychologists. So there are other services
8 available while children are on the wait
9 list.

10 Q. Okay. And I appreciate that. I
11 understand that they can receive other
12 services. But is anything being done to
13 actually limit the amount of children that
14 are currently on the wait list?

15 A. Yes.

16 MS. DOTY: Objection. Vague.

17 Q. Go ahead.

18 A. So we are expanding provider
19 network adequacy. So our managed care
20 organization who has the CSED Waiver, they
21 have to ensure that we have provider
22 adequacy to do that. So they are constantly
23 recruiting. So, you know, they are
24 attritioned -- you know, we are not losing

1 providers. We are gaining providers usually
2 on a quarterly basis.

3 Q. Okay. And that particular -- the
4 wait list for CSED has been -- how long has
5 that been an issue?

6 MS. DOTY: Objection.
7 Mischaracterizes testimony.

8 Q. Go ahead.

9 A. I mean, beginning the program.
10 Because it was during the pandemic. That
11 would probably change the answer because,
12 you know, when you start a program during
13 the pandemic and everybody was at home. So
14 it is very hard to explain in the beginning
15 was there ever a wait list versus now.

16 Q. Understood. How about since 2021?

17 A. Again, we were still under the
18 emergency pandemic order.

19 Q. 2022?

20 A. Still under the emergency pandemic
21 order.

22 Q. So with regard to the emergency
23 pandemic order in 2022, what effect would
24 that have on the CSED wait list?

1 A. So you might have families that did
2 not want providers to come into the home to
3 do service out of fear of getting COVID. So
4 that would have caused, you know, possibly
5 people to wait on the wait list till it was
6 safer they felt for the providers to come in
7 the home to deliver services. So families
8 have a choice.

9 Q. What organizations provide CSED
10 Waiver services?

11 A. Licensed behavioral health centers.

12 Q. Okay. And are you aware that those
13 behavioral health centers are the ones that
14 actually have the wait list -- or I
15 shouldn't say also -- but also have wait
16 lists with regard to providing services to
17 the children that need those waiver
18 services?

19 MS. DOTY: Objection. Vague.

20 A. So we have Aetna, again who is our
21 managed care organization who does that.
22 They give us a total wait list number.

23 Q. Right.

24 A. And they work with those providers

1 to help them onboard individuals to do the
2 services. So if you are like short a
3 therapist and can't take more on the
4 caseload -- Aetna is actively working with
5 them to help them retain and recruit.

6 And then they also have the ability
7 to do geographic exclusions. So CMS grants
8 our ability to do that. So if someone -- if
9 there's an LBHC in a certain area that is
10 full that you are able to use someone for --
11 outside of that catchment area to deliver
12 those services.

13 Q. Okay. Let me ask you this way.
14 Since 2022, has DoHS done anything to
15 address the wait list issue with the CSED
16 Waiver Program -- since 2022?

17 A. Can you clarify what you mean by --

18 Q. Well --

19 A. -- do something?

20 Q. Well, has any actions been taken to
21 address the fact that there is a waiver of
22 -- I'm sorry -- that there is a wait list on
23 the CSED Waiver Program since 2022?

24 A. So they also can receive interim

1 services through the Bureau for Behavioral
2 Health and also through Safe at Home.

3 Q. Right. I understand that. I want
4 to know if there has been any actual -- I
5 mean, is there anything that you can point
6 to that DoHS has done since 2022 to address
7 the CSED Waiver issue?

8 MS. DOTY: Objection. Vague.

9 Q. I mean, I know there's other
10 services provided.

11 A. Right.

12 Q. Is that the only thing that --

13 A. Well, I mean, like I stated, when
14 you have a wait list, it is because you have
15 a lack of providers. So that's why I was
16 explaining with Aetna, how they were working
17 with to develop more providers and use
18 geographic exclusion to ensure we get kids
19 treatment in a timely manner.

20 Q. And they started doing that in
21 2022, or they've been doing that all along?

22 A. We have been doing that since the
23 beginning. But again, pandemic put a little
24 bit of a kink in that.

1 Q. Got you.

2 And that's kind of what I am trying
3 to zero in on. Has anything different been
4 done? And the reason I am pointing to 2022
5 is -- according to the WV report, 31 percent
6 of the organizations that offer CSED Waiver
7 reported that they had wait lists.

8 So that 31 percent in 2022, you
9 know, there is a finite number. And
10 according to what you're telling me, there
11 is already efforts and a way to avoid the
12 wait lists. Was anything different done?

13 A. There has been no changes since
14 '22.

15 Q. Okay. Are you aware of that --
16 from 2022 to 2023, that number went from
17 31 percent to 57 percent?

18 MS. DOTY: Objection. Assumes
19 facts not in evidence.

20 Q. Just asking if you are aware of
21 that?

22 A. I am not aware of the percentage
23 number.

24 Q. I think you started off by telling

1 me that the main focus of the CSED Waiver
2 Program was to reduce number of children
3 going into residential care; is that fair?

4 A. That is correct.

5 Q. Okay. And has that happened?

6 A. We have had cases where children --
7 it may even recommend that they would go to
8 residential care. But we were able to put
9 CSED in place to keep them in their
10 community.

11 Q. Do you have any type of number that
12 represents in the last two or three years
13 how many children have been prevented from
14 going into residential treatment through the
15 CSED Waiver Program?

16 A. I do not, no.

17 Q. Is there any way to track whether
18 or not CSED Waiver Programs are actually
19 being successful?

20 A. We do have outcomes and evaluations
21 required from each care organization.

22 Q. Do any of those outcome metrics
23 include tracking or estimating the number of
24 children that are being prevented from going

1 into residential treatment?

2 A. I do not have that number today.

3 Q. I'm not asking for the number. I'm

4 asking if the number is actually tracked?

5 A. I do not know if it is tracked at

6 the exact way that you are stating.

7 Q. Do you know of any way it is

8 actually tracked?

9 A. We do do tracking on those

10 children. But again, it could be a

11 documentation review. It could be a

12 referral review. But I am not sure if there

13 is an exact mapping of that.

14 Q. Explain to me how the CSED referral

15 works.

16 A. Okay. Again, it can happen

17 multiple different ways. So someone could

18 call 988, or the Children's Mobile Crisis

19 Line. Education can refer. Parents can

20 self-referral. And even providers who are

21 treating individuals in the community can

22 refer. So there's multiple ways that

23 someone could be referred to the program.

24 Q. Bureau of -- BSS -- is it still

1 BSS?

2 A. It is.

3 Q. Trying to keep up.

4 A. That's okay.

5 Q. You guys keep changing too much.

6 Do some referrals come through BSS?

7 A. They do. The workers can refer as
8 well. They work with the family typically
9 to do that, yeah.

10 Q. Is that where the majority of the
11 referrals come from?

12 A. I don't have exactly the number. I
13 mean, it just comes through different
14 multiple things. I would say the majority
15 probably do come from workers. But again, I
16 don't have exact numbers in front of me.

17 Q. And when the child is put into a
18 placement -- foster child is put into
19 placement, the BSS worker -- is there a
20 requirement that the BSS worker does an
21 assessment to determine if that referral
22 needs to happen?

23 A. It is not -- I wouldn't say the
24 worker has an assessment. I think the

1 worker reviews the case. And I think that
2 they refer appropriately. Because we have
3 other waiver programs, not just CSED. So an
4 example could be a child with a cognitive
5 impairment. They may refer them to the IDD
6 Waiver. So there is multiple ways workers
7 look at the case I think to ensure that they
8 have -- you are referring appropriately to
9 the programs needed.

10 Q. Understood.

11 What is IDD Waiver?

12 A. Intellectual Disabled Waiver. They
13 are for individuals with cognitive
14 impairments or severe developmental
15 disabilities. It is also a 1915(c) Waiver.

16 Q. And before I leave CSED, does CSED
17 Waiver Program track the number of children
18 that end up in residential treatment that
19 received CSED Waiver Services?

20 A. We are tracking that as well.

21 Q. What does that number look like?

22 A. I don't have that number.

23 Q. Do we know if that's increasing or
24 decreasing?

1 A. I don't -- I can't make a judgment
2 call on the last time I reviewed that.

3 Q. With the IDD Waiver Program -- let
4 me back up just a second. You mentioned
5 that that's one of the type of referrals
6 that could occur, as well as -- as well as
7 ACT, as well as CSED, as well as IDD. All
8 of those could be referrals done by the BSS
9 worker, correct?

10 A. Absolutely.

11 Q. And is that assessment done through
12 an acronym referred to as CANS?

13 A. We do use CANS and CAFAS to help
14 make determinations.

15 Q. And of the two -- those are the
16 only two, right?

17 A. There is PECFAS. But PECFAS is
18 more for the adult side of things.

19 Q. Yeah. And is it my understanding
20 -- or is it fair to say that CANS is kind of
21 becoming the go-to?

22 A. Yes. We use it, and multiple
23 states use it, for assessment reasons.

24 Q. Okay. And what does CANS stand

1 for?

2 A. Children -- right off the top of my
3 head -- Children --

4 Q. Hold on a second, and I will tell
5 you.

6 A. I have a lot of abbreviations
7 running in my head.

8 Q. You and me both. Is it Child
9 Assessment Needs and Strengths?

10 A. Needs and Strengths, yeah. I
11 couldn't figure out the S. But yes, that's
12 correct.

13 Q. Yeah.

14 When is a CANS assessment done by a
15 BSS worker?

16 MS. DOTY: Objection. It's
17 outside of the scope.

18 Q. At what point -- when a child
19 enters into DoHS custody, at what point is a
20 CANS assessment done?

21 A. It can happen at any point. So it
22 is not just -- you know, you are of course
23 trying to do it on the front end of things.
24 But at any point you can do a CANS

1 assessment.

2 Q. Is there a requirement that it be
3 done within a certain amount of time from
4 when the child is placed into foster care?

5 MS. DOTY: Objection. Outside
6 of the scope.

7 A. I couldn't answer that. I am from
8 Medicaid. So I don't know.

9 Q. Understood.

10 And so from a Medicaid standpoint,
11 you don't know at what point in time a child
12 who enters foster care is determined to need
13 or not need those Medicaid services?

14 A. That's not connected to Medicaid
15 exactly. So that's -- you know, CANS is an
16 overall assessment for children. And there
17 is other, you know, assessments. Somebody
18 might do a psychological evaluation as well
19 to establish medical necessity.

20 So Medicaid is the payor. So we --
21 you know, based upon assessments that are
22 done -- it could be multiple assessments.
23 That determines medical necessity and
24 determines levels of care needed and things

1 like that. So it is not just one thing that
2 could make that determination. There could
3 be multiple pathways. But CANS is required
4 -- one of the required assessments.

5 Q. When a child enters the foster care
6 system, enters DoHS custody, what's your
7 understanding of how it is determined
8 whether or not that child needs IDD Waiver
9 Services or CSED Waiver Services?

10 MS. DOTY: Objection. Outside
11 of the scope.

12 A. Again, I am the payor. So that is
13 not connected to the part that I do with the
14 worker.

15 Q. So you don't have any information
16 as to whether or not the services were
17 actually -- how it is being determined if
18 those services are needed or when it has
19 been determined if a child needs those
20 services; is that fair?

21 A. We pay, once it is established,
22 whatever service that they are needed.

23 Q. So when we talk about the wait
24 lists with CSED Waiver Program -- and we

1 will get into the ones with IDD Waiver and a
2 couple of others -- you wouldn't have any
3 information as to whether or not there is
4 children out there who have not yet been
5 assessed that would also be on that wait
6 list?

7 A. I would not have that information.

8 Q. Okay. Back to -- real quick, back
9 to the CSED Waiver Program. You told me
10 that you are in the process of tracking
11 children that receive CSED Waiver Services
12 and end up in residential treatment,
13 correct?

14 A. Our managed care organization is
15 tracking that.

16 Q. How is that being tracked?

17 A. I wouldn't be able to explain the
18 process. We order that their managed care
19 organization develop an ability to do that.

20 Q. Do you know if they are actually
21 doing that?

22 A. I have seen reports, but I can't
23 tell you what was on the last report.

24 Q. No. I just want to make sure that

1 it is -- telling them to do something and
2 seeing that they are actually doing it are
3 two different things. So you have actually
4 seen reports that are tracked?

5 A. I have seen a report. But again, I
6 can't tell you the exact algorithm that they
7 use to develop that report.

8 Q. Sure.

9 Explain to me what IDD Waiver
10 services are.

11 A. So for children and adults who
12 have, again, cognitive impairments, severe
13 developmental disabilities, the IDD Waiver
14 is used to have services. And IDD Waiver
15 has been around probably 30 years in West
16 Virginia. And that really is the goal, is
17 -- I am sure you have heard of group homes
18 and that type of things like that.

19 So the goal of IDD Waiver was to
20 have individuals be able to stay in their
21 community and get programs such as respite
22 or day rehabilitation programs, personal
23 support services and things like that. So
24 similar to CSED, but you are talking about a

1 different target population.

2 Q. And that's everything from infants
3 to seniors, correct?

4 A. I think you have to be -- and
5 again, please don't quote me because I don't
6 do IDD Waiver. I think you have to be at
7 age four and above before you can apply for
8 the IDD Waiver.

9 Q. And specifically with regard to
10 children in foster care, are you aware that
11 there are wait lists for IDD Waiver
12 services?

13 A. Again, I don't do ID Waiver. So I
14 don't know -- have no access to that
15 information.

16 Q. Okay.

17 A. That's a different section of
18 Medicaid.

19 Q. Got you.

20 IDD Waiver would be considered
21 community-based services, wouldn't they?

22 A. It is under the home community-
23 based services rule.

24 Q. But because of the section of BSS

1 that you work for, you don't -- you can't
2 testify about anything --

3 A. I'm BMS.

4 Q. I'm sorry?

5 A. I'm BMS.

6 Q. BMS. Sorry. I've even got it
7 written down.

8 A. So you have different 1915(c)'s.

9 Q. Right.

10 A. And IDD is one of them. And it is
11 under a different section at our bureau.

12 Q. What about positive behavioral
13 support services?

14 A. So we have always had behavioral
15 manager services. And positive behavior
16 supports is an evidence-based model. So we
17 are in -- we are requiring -- we are redoing
18 our policies right now to have providers use
19 that particular evidence-based model when
20 they are doing positive -- positive behavior
21 support is just like a form of behavior
22 management. And typically there is an
23 implementation in development. So you
24 develop a plan, and positive behavior

1 supports helps the families and individuals
2 working with the individual to implement the
3 set plan.

4 Q. And who provides those services?

5 A. Licensed behavioral health centers.

6 Q. And what if anything has DoHS done
7 in the last three years to increase the
8 accessibility to the licensed behavioral
9 health services specifically for providing
10 positive behavioral support?

11 A. BBH -- and again, I do not work for
12 BBH -- created a pilot to work with Concord
13 University to develop certification for that
14 evidence-based model. We in turn took that
15 pilot, and we are now drafting out policy
16 and developing rates and codes so it would
17 be a billable service at Medicaid instead of
18 just behavior manager services without an
19 evidence-based model.

20 Q. So that's something that you are
21 currently doing to increase accessibility to
22 BPH -- PB -- wow -- positive behavioral
23 services?

24 A. PBS.

1 Q. PBS?

2 A. Yes.

3 So when you create a rate and a
4 code, it enables sustainability for
5 providers to ensure that they will be paid
6 for services using certain models or certain
7 services.

8 Q. Okay. And when did that -- when
9 did DoHS begin working on that model or
10 begin working on making that a separate
11 billable entity for PBS?

12 MS. DOTY: Objection. Vague.

13 A. Again, I do not work for BBH. So I
14 do not know when they started the pilot
15 program. I can tell you it was in 2023 when
16 Medicaid made the decision to in 2024
17 develop codes and rates for that.

18 Q. Okay. Prior to 2023, are you aware
19 of anything that DoHS has done to increase
20 the availability of services to positive
21 behavioral support services?

22 MS. DOTY: Objection. Outside
23 of the scope.

24 A. I do not know when BBH started the

1 pilot program.

2 Q. Other than that program --

3 A. Yes.

4 Q. -- are you aware of anything else
5 that DoHS has done to increase accessibility
6 to these services?

7 MS. DOTY: Objection. Outside
8 of the scope.

9 A. Before that, no, I do not know.

10 Q. And would positive behavioral
11 support services be considered wraparound
12 services --

13 MS. DOTY: Objection.

14 Q. -- or community-based services?

15 MS. DOTY: Objection. Vague.

16 A. It is a community-based service.

17 Q. Are you aware of the wait list that
18 is associated with the licensed behavioral
19 health providers that provide the positive
20 behavioral support services?

21 MS. DOTY: Objection. Vague.

22 A. I would need you to clarify. There
23 is not a wait list for LBHCs.

24 Q. You aware of any wait lists with

1 the positive behavioral support services?

2 A. We have not started them yet. It
3 would start in the fall of '24.

4 Q. So prior to 2023, DoHS hasn't
5 provided behavioral health services at all?

6 MS. DOTY: Objection. Outside
7 of the scope.

8 A. BBH piloted the program. I do not
9 work for BBH. So I cannot speak to if they
10 had a wait list or not.

11 Q. Then that means -- I am confused,
12 and you need to clarify for me.

13 All right. I am going to hand you
14 what I am having marked as Deposition
15 Exhibit Number 1.

16 (Exhibit 1 was marked.)

17 Q. Are you familiar with the SME --
18 2024 SME report?

19 A. I have viewed it, yes.

20 Q. If you go ahead and flip to page 64
21 of the report --

22 A. Okay.

23 Q. -- you will see there is an
24 overview section talking about behavioral

1 support services. Are these the same
2 behavioral support services that we are
3 talking about?

4 MS. DOTY: Objection. Outside
5 of the scope.

6 A. In the bottom two paragraphs -- I
7 would like to clarify that that's what you
8 are asking about. Where do you want me to
9 look?

10 Q. Oh, just the -- I mean, it says --
11 should be -- make sure we are on the same
12 page -- 64.

13 A. Okay.

14 Q. Yeah, sorry. I hate double-
15 sided --

16 A. That's okay.

17 Q. So do you see where they are
18 talking about behavioral support services
19 where it starts with the overview under 3.8.

20 A. Yes. But behavior support services
21 is not the same thing as PBS. So PBS is a
22 model of doing behavior support services.

23 Q. So it is the manner in which they
24 do it? It's not just the behavioral support

1 services as a whole?

2 A. Right. So behavior management
3 again would be a form of behavior support
4 services, which we already cover at
5 Medicaid. We are just saying we are going
6 to cover -- we are pushing the
7 evidence-based model forward.

8 Q. Got you. Then help clarify this
9 for me. If you look down at the very
10 bottom, the last full paragraph says, As
11 previously addressed. Do you see that
12 there?

13 A. So, again, that would be with BBH's
14 pilot program. So it says at the bottom,
15 slots for the BBH, PBS program.

16 Q. So that's strictly BBH, and it's
17 not DoHS?

18 A. That is DoHS but not Medicaid.

19 Q. So tell me again, what's BBH?

20 A. Bureau for Behavioral Health.

21 Q. And that's not under Medicaid?

22 A. No. We are separate bureaus. So
23 Bureau for Medical Services and Bureau for
24 Behavioral Health under DoHS.

1 Q. I thought there was -- so there's
2 no Medicaid at all under BBH?

3 A. No. Those are separate --
4 completely separate bureaus.

5 Q. All right. Thank you.

6 So the non -- so BBH has started
7 the program. You all are -- when I say you
8 all -- BMS is adopting the program, but have
9 not yet done so?

10 A. That's correct.

11 Q. So BMS implementing this model --
12 are you going to be providing the same
13 services -- it will be the same -- typically
14 the same services that BPH -- BBH is
15 providing, correct?

16 MS. DOTY: Objection. Vague.

17 A. Yes. We are taking their pilot
18 program and putting it in sustainability for
19 Medicaid payment.

20 Q. But it will be different providers,
21 I would imagine?

22 A. No.

23 Q. Same providers?

24 A. Yes.

1 Q. But you'll be adding Medicaid
2 recipients?

3 A. They could get it now through the
4 pilot program. We are making it sustainable
5 through Medicaid to ensure for, one, is
6 payment, two, tracking and data, claims and
7 information. So what it does is -- when you
8 have a pilot program, they're typically --
9 it is a short-term grant-funded thing. So
10 what we're doing is saying we are going to
11 take this and make it sustainable through
12 Medicaid for reimbursement for the
13 providers.

14 Q. And I guess my concern here -- or
15 my question is, is if they are reporting
16 wait lists through the providers under the
17 BBH program, with you all taking on the
18 program -- or taking on the program for
19 foster children, is anything being done to
20 address the fact that there currently is
21 wait lists in the program that you are
22 creating or adopting?

23 MS. DOTY: Objection. Vague.

24 A. The expectation is, since Medicaid

1 was sustained, that more providers will come
2 on board. Sometimes it is difficult when
3 you grant fund something because it is short
4 term. Many providers don't want to take
5 that upon. With Medicaid becoming the payor
6 -- as a permanent payor, we believe more
7 providers will come on board with that, and
8 we will probably not have a wait list or we
9 will have a small wait list, which again
10 would be tracked by the managed care
11 organizations once it becomes a Medicaid-
12 payable service.

13 Q. When do they expect that to go
14 live?

15 A. Again, fall of '24 is the tentative
16 date for that policy to be in effect.

17 Q. So until that pilot program
18 actually goes live so to speak, there is no
19 way of knowing whether or not it is going to
20 have an effect on the wait list; is that
21 correct?

22 MS. DOTY: Objection. Outside
23 the scope.

24 A. The pilot program -- so it's

1 separate. So it is not a pilot program. It
2 is Medicaid. It's Medicaid sustained.

3 Q. Right. But your premise is that
4 once it becomes a Medicaid-billable service,
5 you will get more providers and hopefully
6 reduce the wait lists. Through your-all's
7 program, are you going to be adding more
8 Medicaid individuals now that you are
9 receiving services?

10 A. If an individual has Medicaid and
11 they meet medical necessity for that
12 service, they can receive the service.

13 Q. I understand that. But there's
14 already individuals under BBH?

15 A. Correct.

16 Q. So my question is, are you just
17 taking individuals already receiving
18 services under BBH, or are you going to be
19 adding new individuals receiving services
20 under BMS?

21 A. If they meet medical necessity for
22 the service, they would get it. So it would
23 be not just the pilot people but anybody on
24 Medicaid who meets medical assessment.

1 Q. Right. So you are going to be
2 increasing the number of people receiving
3 those services?

4 A. That is a possibility, yes, that's
5 correct.

6 Q. Do you know of the current
7 providers, if any of those are going to be
8 Medicaid eligible?

9 MS. DOTY: Objection. Vague.

10 A. Providers are enrolled -- I am just
11 going to clarify. Do you mean members or
12 providers?

13 Q. I mean the providers under BBH, the
14 ones that are currently providing these
15 services under BBH, are they going to
16 qualify under the program that DoHS is
17 implementing under BMS?

18 MS. DOTY: Objection. Vague.

19 A. My understanding from BBH is, they
20 are already enrolled in Medicaid as
21 providers.

22 Q. All of them?

23 A. My understanding from BBH, they
24 are.

1 Q. Are there any other programs that
2 have been initiated by -- I'm sorry. Strike
3 that.

4 Are there any other programs -- BBH
5 programs that BMS is going to be adopting or
6 is looking at adopting to increase
7 accessibility?

8 A. We already did Children's Mobile
9 Crisis. So that was a pilot program through
10 BBH, which we had a state plan amendment
11 approved from CMS. So we already have that
12 approved and have already certified teams
13 for Mobile Crisis.

14 Q. Any others?

15 A. Not at this time, no.

16 Q. Throw another acronym at you and
17 ask you to define this so I don't have to
18 look it up.

19 A. I'll try.

20 Q. RMHTFs?

21 A. Residential mental health treatment
22 facilities.

23 Q. Thank you.

24 What if anything has DoHS done

1 since 2022 to increase access to RMHTFs?

2 MS. DOTY: Objection. Outside
3 of the scope.

4 A. I wouldn't say there was increase.
5 I think we developed community-based
6 services to try to stop children from going
7 to facilities. There is nothing we have
8 done to open up more access to facilities.
9 We put more community-based services in
10 place to ensure that children could stay in
11 the community more than go into the
12 facility.

13 Q. Okay. And we talked about the CSED
14 Waiver Program as one of those programs,
15 correct?

16 A. That's correct.

17 Q. And what other programs have been
18 created, or what -- let's start with that.
19 What other programs have been created to
20 accomplish that goal?

21 A. Well, Children's Mobile Crisis is
22 one of them. So if someone is having a
23 crisis, a crisis team is sent out to the
24 home. And a lot of times that stops

1 children from going into emergency
2 departments, which then could lead to a
3 facility-based level of care.

4 So that's probably the children's
5 crisis team. They go out and assess the
6 situation. They are also able to schedule
7 appointments immediately, the next day.
8 Sometimes get them on the phone with the
9 psychiatrist of the LBHC or with the
10 clinical supervisor to get something set up
11 immediately so we can stop that individual
12 from possibly going into a facility-based
13 care.

14 Q. And is there any matrix or any
15 manner in which to track how many children
16 are being prevented from going into RMHTFs
17 through the Child's Mobile Crisis Program?

18 A. There is not a matrix developed.

19 Q. Has there been -- well, strike
20 that.

21 Other than the Children's Mobile
22 Crisis, any other programs or services that
23 have been developed to help children from
24 being -- or from going into the RMHTFs?

1 MS. DOTY: Objection. Outside
2 of the scope.

3 A. We are in the process right now of
4 developing CCBHCs in West Virginia -
5 Comprehensive Community Behavioral Health
6 Clinics.

7 Q. Hold on just a second. CCHB --

8 A. CCBHC.

9 Q. I can't tell -- too many C's in
10 that. CCBHC?

11 A. CCBHC. And those are comprehensive
12 community behavioral health clinics. And
13 that is a federally recognized provider
14 type. And our state -- in development of
15 CCBHCs, states are allowed to require
16 certain services. So we are requiring all
17 CCBHCs -- they must be a CSED provider.
18 They must have a Children's Mobile Crisis
19 team. And they must have intensive
20 outpatient programs for youth and
21 adolescents.

22 Q. Give me an example of a CCBHC.

23 A. So, again, we are submitting a
24 state plan amendment this month for

1 approval. But an example would be like --
2 Prestera is a comprehensive mental health
3 center that is planning to apply to become a
4 CCBHC. These comprehensive and LBHCs can
5 render any services in Chapter 503 of our
6 Medicaid manual.

7 But with this designation, because
8 of the way the payment structure is, we can
9 require them to do certain services, not
10 just you have an option to do them. We are
11 saying you have to serve certain populations
12 and you must do these certain services. So
13 with that, that will expand CSED Waiver
14 providers, Children's Mobile Crisis teams
15 and intensive outpatient programs for youth.

16 Q. And of those programs you just
17 mentioned, how many of them are Prestera
18 currently providing?

19 A. I'm sorry. Of the programs right
20 now?

21 Q. Yes.

22 A. They have a CSED Waiver -- they are
23 a CSED Waiver provider. And I believe they
24 are applying with the Mobile Crisis Team. I

1 am not sure if they have one in place just
2 yet.

3 Q. How long has the Mobile Crisis
4 Program been in effect?

5 A. Since we -- we had a state plan
6 amendment approved in September of '23. And
7 our policy was effective February of '24.

8 Q. And as far as the CSED Waiver
9 Program -- of the providers that you
10 anticipate identifying as CCBHCs, do most of
11 them already provide CSED Waiver?

12 A. I would say no based on it. But
13 again, we don't know who all will apply. So
14 it is not in effect yet. So we are not sure
15 who all will apply.

16 Q. I'm sorry. When is that going to
17 go into effect?

18 A. We are submitting the state plan
19 amendment this month. So we do not know
20 when CMS will have an effective date on
21 that. But we do believe it will be by the
22 end of '24 at latest.

23 Q. Other than -- hold on. I want to
24 make sure I got your complete answer because

1 we went off on a tangent. Children's Mobile
2 Crisis, CCBHC -- what other, if any, efforts
3 is DoHS taking to reduce the number of
4 children going into RMHTFs?

5 MS. DOTY: Objection. Outside
6 of the scope.

7 A. I believe I have named the
8 majority.

9 Q. I just want to make sure.

10 A. Yeah. I believe I named the
11 majority of those services that have been
12 placed by Medicaid.

13 Q. And of the services that -- and I
14 understand several of these have not taken
15 place yet, or at least a few of them are
16 planning on going into effect. Have you
17 realized any reduction in the actual amount
18 of children going into the RMHTFs?

19 A. Aetna has reported to me that there
20 has been a decrease in that. We don't know
21 if it is connected to CSED or the other
22 community-based services that have been put
23 in place. It could be for multiple reasons
24 that that number went in.

1 Q. Are you aware of the increase in
2 the wait lists to RMHTFs?

3 MS. DOTY: Objection. Vague.

4 A. No, I cannot.

5 Q. When you take over the program --
6 take over is a bad -- when you implement
7 plans that are currently being implemented
8 by BBH, such as the -- did you ask where
9 CCBHCs came from?

10 A. No.

11 Q. No, that was separate?

12 A. Yeah.

13 Q. Okay. Strike that. Let me ask you
14 this way.

15 Prestera provides IDD Waiver
16 services, right?

17 A. I don't -- I am not over IDD, so I
18 don't have access to those providers.

19 Q. You say it does provide CSED Waiver
20 Services?

21 A. Correct.

22 Q. So if there is a wait list for IDD
23 Waiver and CSED Waiver, both of which
24 provided Prestera and you are adding more

1 responsibilities to them, what confidence do
2 you have that they will be able to actually
3 handle the services it can be asked to
4 provide?

5 MS. DOTY: Objection. Outside
6 the scope.

7 A. The IDD Waiver and CSED are
8 different populations. So they are not
9 connected in any way.

10 Q. Right. But, I mean, Prestera is
11 only -- I mean, I don't want to assume
12 anything. Everybody knows who Prestera is.
13 They only have so many employees. So if you
14 are adding more programs, more services -- I
15 understand that you have got multiple wait
16 lists.

17 I guess my question is, has DoHS
18 done anything to make certain or to assure
19 that when Prestera is being asked to provide
20 these additional services that they can
21 actually do it?

22 A. So there was a demonstration grant
23 that was won by West Virginia for CCBHCs,
24 and that gave dollars to providers,

1 including Prestera, to develop more
2 workforce to become a CCBHC provider.

3 Q. Are you aware that part of the
4 reason Prestera, like other behavioral
5 health centers, identify as the reason --
6 strike that. It's a horrible question.

7 With regard to CSED -- CSED Waiver
8 Program specifically, do you know why
9 there's wait lists?

10 MS. DOTY: Objection. Vague.

11 A. There could be multiple reasons for
12 a wait list. There could be an influx of
13 one time of one area getting more children.
14 Also, you know, once school is in session,
15 you are going to get more referrals versus
16 in summer and November and December when you
17 probably will have less referrals. So there
18 is a fluctuation usually of the wait list
19 depending on that.

20 Q. Separate from fluctuations -- and I
21 understand there is obviously always
22 environmental aspects that can make things
23 go up and down. I mean, there has been a
24 constant increase in percentage of wait

1 lists from 31 percent of organizations to
2 57. Do you know if DoHS has looked in to
3 determine why that is?

4 MS. DOTY: Objection. Outside
5 the scope.

6 A. I believe that has been reviewed.
7 And partially is, it does take a while to
8 train new employees with wrap-around and
9 evidence-based practices. So it is not like
10 you can hire someone and they can
11 immediately go to work too.

12 So you are talking about at least a
13 two to four-week session of them being
14 trained before at times or even with
15 families and with children to do that. And
16 then, you know, there are times employees,
17 that is not -- they realize through the
18 training that that's not the population they
19 want to serve, and they go a different
20 route. Again, there's multiple reasons why
21 there could be an increase in the number.

22 Q. Do you have an understanding of how
23 long there has been a wait list with regard
24 to CS&ED Waiver?

1 A. No. Because again, the pandemic
2 put kind of a kink in our data. So it is
3 really hard to judge based on 2021 and '22.

4 Q. What about prior to the pandemic?

5 A. It wasn't in effect. We went in
6 effect during the pandemic in '20.

7 Q. And out of the 30 individuals that
8 are currently on the CSED wait list, do you
9 know how many organizations that it
10 represents?

11 A. I do not.

12 Q. Other than Prestera, what other
13 behavioral health facilities are you aware
14 of that plan to apply for the CCBHC license?

15 A. We have six provisional right now
16 that have informed us that they will. But
17 once we have a state plan amendment, there
18 could be more. Currently, it would be
19 Prestera, Seneca, Southern Highlands, Valley
20 -- I am thinking of everybody. Prestera,
21 Seneca, Southern Highlands, Valley, FMRS --
22 and I am missing one. I'm sorry. I am
23 missing one off the top of my head. I
24 apologize.

1 Q. I am surprised you got five.

2 A. I have to think about it here. So
3 Presteria, Seneca, Southern Highlands, FMRS,
4 Valley. I am trying to think. We have six.
5 I can't think of the sixth one right off the
6 top of my head.

7 Q. When DoHS -- and my apologies. I
8 know I asked this. I can't remember exactly
9 what the answer was. What other programs
10 that BBH operates that DoHS has kind of
11 modeled or decided to take on? You have the
12 Children's Mobile Crisis Program. What
13 else?

14 MS. DOTY: Objection. Vague.

15 A. PBS.

16 Q. PBS?

17 A. And then also CCBHC started, which
18 SAMHSA -- which is the federal entity that
19 funds money to BBH.

20 Q. Okay. So all three of those were
21 under BBH -- or where DoHS became aware of
22 them because they are being operated by BBH?

23 MS. DOTY: Objection. Vague.

24 A. Yes.

1 Q. Did DoHS take a look at the success
2 that BBH was having in terms of
3 accessibility, wait lists, things of that
4 nature in deciding to take on these
5 programs?

6 MS. DOTY: Objection. Vague.

7 A. So when they pilot a program, they
8 will do it anywhere from maybe two years to
9 five years. And then we meet with Medicaid.
10 And then we look at it. CCBHC is actually a
11 state law that was passed here that we had
12 to do a state plan amendment. That was
13 required by the state law on how the payment
14 structure of that was. But again, the money
15 and the demonstration did come through BBH.

16 So we did look at PBS and Mobile
17 Crisis. We saw the success. We also had
18 hospital feedback that said this was helping
19 them with EMEDs, with children coming there.
20 So we knew that was something that we wanted
21 to do. And so at that point we decided how
22 we would do that.

23 One was state plan amendment. We
24 did not have to do a state plan amendment

1 for PBS because we already had behavioral
2 management under mental health rehab state
3 plan.

4 Q. I'm sorry. Say that last part
5 again.

6 A. I'm sorry.

7 Q. That's all right. That last part
8 you just said, I didn't quite catch that.

9 A. Sorry. So we did not have to do a
10 state plan for PBS because it is a model --
11 because we already have mental health
12 rehabilitation state plan which included the
13 behavioral management. We are just stating
14 they are going to use a model to do behavior
15 management services.

16 Q. So you weren't adding a new
17 service, you were just changing the language
18 you were providing it?

19 A. It actually is an additional
20 service. So you have behavior management,
21 and then you have people who are certified
22 to do PBS. So we are not taking away
23 behavioral management, we are saying you are
24 using the evidence-based model and certified

1 individuals to do it.

2 Q. So with regard to the programs that
3 you've identified -- well, it's not in
4 effect yet, so I can't ask that question.

5 How do you monitor the success rate
6 of the CSED Waiver Program?

7 MS. DOTY: Objection. Vague.

8 A. We have metrics in place. Our
9 managed care organization is put together --

10 Q. Right. But, I mean, what are you
11 looking at to say this is working?

12 MS. DOTY: Objection. Vague.

13 A. Again, I don't have those right in
14 front of me right now, the metrics.

15 Q. Okay.

16 MS. DOTY: Can we take a break?

17 MR. WALTERS: Absolutely.

18 (Break in proceedings from
19 9:45 to 9:58 a.m.)

20 BY MR. WALTERS:

21 Q. I think you told me -- but let me
22 ask you because I am not positive -- that
23 there was a means by which the managed care
24 group -- or the managed care company is

1 tracking the success of keeping children out
2 of residential treatment facilities?

3 MS. DOTY: Objection. Vague.

4 A. They are supposed to be doing that,
5 yes.

6 Q. And those numbers -- I mean, is
7 that -- what I am trying to -- what I am
8 trying to get at in a horrible way is, how
9 is BMS and DoHS tracking or determining
10 whether or not these programs - you know,
11 absent the ones that haven't started - are
12 keeping kids from going into residential
13 treatment centers?

14 MS. DOTY: Objection. Outside
15 of the scope.

16 A. They have -- especially Children's
17 Mobile Crisis because it's just become a
18 Medicaid service. They are working on the
19 development of metrics so -- in reporting.

20 So, for an example, it could be the
21 child went to the emergency department and
22 the parents were like we think they need to
23 go in-patient somewhere, but the Children's
24 Mobile Crisis was able to, you know, put

1 them in connection with appointments and
2 ensure that they had community-based
3 services so they did not go in the program.

4 So this was an example of something
5 that they would have to track. So I believe
6 in Children's Mobile Crisis, there is a
7 development right now of a reporting form on
8 that.

9 Q. Do you know whether or not that
10 tracking would include they didn't go within
11 the next 30 days, 60 days, 90 days, as
12 meaning we have stopped it from happening?

13 A. I do not know. Again, I believe
14 that particular part is in development
15 because it is a newer service.

16 Q. What about the -- is that type of
17 tracking done for the CSED Waiver Program?

18 MS. DOTY: Objection. Vague.

19 A. My understanding is that there is.
20 I do not have that report in front of me.
21 So I do not know the algorithm or metrics
22 that were developed with that.

23 Q. And, I mean, is it fair to say that
24 the purpose or the goal of these community-

1 based services are to prevent in-patient
2 care or residential treatment placement?

3 MS. DOTY: Objection. Outside
4 of the scope.

5 A. That is correct.

6 Q. Okay. So in assessing whether or
7 not these community-based services are
8 actually working, those would be the numbers
9 -- numbers of in-patient and number of
10 individuals or children in foster care being
11 placed in residential treatment --
12 residential treatment facilities would be an
13 important matrix for DoHS?

14 MS. DOTY: Objection. Outside
15 of the scope.

16 A. It could be one of them. But there
17 could be multiple factors to that.

18 Q. And let's go back to that IDD
19 Waiver a second. I think you told me that
20 you are not over -- you're not over IDD
21 Waiver?

22 A. No.

23 Q. Don't have anything to do with IDD
24 Waiver?

1 A. No.

2 Q. But IDD Waiver, I thought -- isn't
3 there Medicare IDD Waiver?

4 MS. DOTY: Objection. Vague.

5 A. Medicaid. You said Medicare.

6 Q. Sorry. Medicaid. I meant
7 Medicaid.

8 A. Yeah. So there are different types
9 of 1915(c)'s. So CSED Waiver is one of
10 them. And because it is behavioral health
11 related, and I'm the behavioral health
12 director, it is in my unit. While there is
13 another unit that does the IDD, the ADW and
14 the TDI.

15 Q. And so ADW -- of course we are not
16 dealing with ADW and the IDD. So if you are
17 dealing with IDD in the realm of BMS, that's
18 going to be through CSED?

19 MS. DOTY: Objection. Vague.

20 A. No. Those are separate waivers.

21 Q. Okay.

22 A. Separate target populations are
23 served.

24 Q. And what I am trying to get a

1 handle on, that I obviously don't understand
2 is -- I thought there was foster care
3 children that received IDD Waiver services
4 through Medicaid?

5 A. There are. But again, that would
6 be children in foster care with a cognitive
7 impairment who meet the qualifications for
8 IDW. You might have children in foster care
9 that have mental health conditions. That is
10 CSED Waiver.

11 Q. Okay.

12 A. So it is a different --

13 Q. So the children in foster -- sorry.
14 I didn't mean to cut you off.

15 A. That's okay.

16 Q. The children in foster care that
17 have the IDW through Medicaid, that would
18 not be in your purview?

19 A. That is correct.

20 Q. That would be BBH?

21 A. No.

22 Q. Who would that be?

23 A. Okay. So we are Medicaid --

24 Q. Right.

1 A. -- under DoHS.

2 Q. Right.

3 A. And then you have 1915(c) waivers.

4 Those are defined as home and
5 community-based waivers.

6 Q. Uh-huh.

7 A. You have the IDW Waiver, ADW
8 Waiver, the TBI Waiver, and the CSED Waiver.
9 Okay? Those are all separate 1915(c)'s.

10 Q. Got you.

11 A. Okay. What target populations that
12 they serve.

13 So that is Medicaid. We are the
14 payor of that. So a child that is on the
15 IDD Waiver could be a foster child, could
16 not be a foster child.

17 Q. Right.

18 A. But they have a severe cognitive
19 impairment or a developmental delay, so they
20 are served in that waiver for children who
21 are --

22 Q. Okay. And that's what I want to
23 talk about. So when you are talking about
24 those children in that waiver, who is that

1 under? I know it's under --

2 A. Randy Hill's. That's a separate
3 director.

4 Q. Okay.

5 A. It is a separate unit.

6 Q. In BMS?

7 A. In Medicaid, yes.

8 Q. So it is in BMS. It's in Medicaid.
9 It is the IDW Waiver. And you can't talk
10 about it because it is not over -- that's
11 not something that you are prepared to talk
12 about?

13 A. That is not my area.

14 Q. I understand.

15 Has BMS or DoHS looked into causes
16 of community-based program services --
17 delays in children getting community-based
18 services?

19 MS. DOTY: Objection. Outside
20 of the scope.

21 A. Yes. We have reviewed, you know,
22 certain individual cases. Aetna has brought
23 cases to us to inform us there is a delay
24 for certain reasons. It could be even that

1 the parent refuses services. So there is a
2 freedom of choice. The family has a right
3 to refuse a service even if the child meets
4 medical necessity criteria.

5 So there's multiple reasons why
6 services have not taken place. And so we
7 look at those. If there is something that
8 could be a barrier that we feel like we can
9 work with the family or work with other
10 entities, if that's the situation, then we
11 do that.

12 So we do have what we call like
13 case sessions where we have a particular
14 issue, we are bringing it to DoHS or
15 Medicaid in particular. They kind of staff
16 it. And then we talk about what we can do
17 to eliminate those barriers.

18 We have even had times where we
19 think that the parents just need more
20 education about the program. We are not,
21 you know, coming in to like take your child.
22 We are actually coming in to put services in
23 your home to ensure your child can stay with
24 you.

1 Q. And when you do that review, do you
2 have any type of -- is there a report out
3 there that says we have identified these
4 reasons or -- you know, yeah. Is there a
5 report of anything that identifies the
6 reasons that you have identified causing
7 these delays in community-based services?

8 MS. DOTY: Objection. Vague.

9 A. I don't believe there is a detailed
10 report. I think there is an overall report
11 of like if there are children on the wait
12 list or on hold or things like that.

13 Q. And you mentioned wait list. I
14 mean, fair to say that when you do that
15 review, part of the reason -- or at least
16 one of the causes is wait lists, receiving
17 community-based services; is that fair?

18 MS. DOTY: Objection. Vague.

19 A. We do review that, yes.

20 Q. And there are wait lists, and that
21 is part of the cause; is that fair?

22 MS. DOTY: Objection. Vague.

23 A. There is 30, as I stated earlier.

24 Q. Sorry. Can you repeat that?

1 A. There is 30 as of June 14th, as I
2 stated earlier.

3 Q. That's just with the CSED?

4 A. Right.

5 Q. I am talking about in general,
6 community-based programs -- services?

7 A. No. Because that's very different.
8 That's program specific.

9 Q. One of the programs that you
10 mentioned early on was the ACT Program,
11 correct?

12 A. That's correct.

13 Q. I think I asked you if you know how
14 many were in it. And you do not know,
15 correct?

16 A. No. We have approved teams. And
17 those teams can have up to 125 individuals
18 on those teams.

19 Q. Are you aware that in -- what year
20 are we in, 2024 -- middle of last year, that
21 there was only five foster care or youths
22 under the age of 21 receiving ACT Services?

23 A. I don't have the number in front of
24 me.

1 Q. Would that surprise you?

2 MS. DOTY: Objection. Outside
3 of the scope.

4 A. That there were that many
5 individuals getting services for ACT?

6 Q. That few.

7 A. Well, you have to understand it is
8 only 18 to 21. So, no, I am not --

9 Q. I'm sorry. Between 18 and 21?

10 A. Right. But the service is for 18
11 and up.

12 Q. Right.

13 A. So compared to, you know, 22 to 64,
14 you are going to have a less population for
15 18 to 21.

16 Q. Right. So I guess what I'm -- when
17 I asked you about programs that DoHS has
18 implemented to help provide community-based
19 services to foster children, ACT was
20 mentioned. But as you said, ACT is only 18
21 to 21?

22 A. That's correct.

23 Q. So it is only going to target a
24 very limited portion of the foster care

1 community?

2 A. Right. But you have CSED Waiver
3 which is --

4 Q. Right.

5 A. -- which is -- if you look at it,
6 it is almost ACT-like in a sense because you
7 have wraparound.

8 Q. You said ACT-like, not ACT light?

9 A. Like, L-I-K-E.

10 Q. That's important.

11 A. Yeah.

12 So when you look at it that way --
13 so you almost have a program for adults and
14 children. So the 18 to 21 is always an
15 interesting population because they can
16 sometimes receive children's services still
17 because they are under 21 or adult services
18 because they are 18 and up.

19 Q. When DoHS looked -- and we talked
20 about looking at BBH for programs, and you
21 mentioned the CCBHC and CSED and BPS -- PBS?

22 A. PBS.

23 Q. I don't know why it is so hard.

24 Were those programs chosen

1 specifically to reduce the amount of
2 individuals -- amount of foster care
3 children going into residential treatment?

4 MS. DOTY: Objection. Outside
5 of the scope.

6 A. I think they were developed for all
7 children, not just ones in the foster care
8 system. So it was all children we were
9 focused on to ensure that they didn't have
10 to go into facility-based care.

11 Q. Right. But the purpose is to
12 prevent the introduction of children into
13 residential treatment?

14 MS. DOTY: Objection. Outside
15 of the scope.

16 A. Your goal is to develop more
17 community-based services to do that, that is
18 correct.

19 Q. And I think -- is there any program
20 out there that DoHS has -- through the
21 Medicaid program, are there any other
22 programs out there that -- whose goal is to
23 prevent children from going into residential
24 treatment facilities that we haven't talked

1 about?

2 MS. DOTY: Objection. Outside
3 of the scope.

4 A. I believe it mentioned intensive
5 outpatient services. So we are going to
6 require CCBHCs to do that for the youth. We
7 already do have some intensive outpatient
8 programs for children.

9 And so what that does is, instead
10 of just like if you went to therapy once a
11 week, it is actually a three-day or five-day
12 program that children go to. We work with
13 the Department of Education to ensure the
14 kids still get their education. But they
15 are there between four to six hours a day to
16 receive group therapies, individual
17 therapies, supportive counseling and
18 targeted case management.

19 So that is also -- like they come
20 to the program, but they go home in the
21 evenings. So we are still like on the
22 continuum. You might have basic outpatient,
23 intensive outpatient. And then further down
24 the line, you might have residential care.

1 So, again, that's another type of service in
2 the community to try to ensure that they can
3 stay in the community.

4 Q. That's a new program?

5 A. No. Intensive outpatient program
6 has been around for 25 years maybe.

7 Q. Okay. I misunderstood you. I
8 thought you said it was new. I am like,
9 that doesn't sound --

10 A. No. That is not new. But yeah, it
11 is in place. But with the requirement of
12 CCBHCs having to have them. Where they
13 could have done it before, now they will be
14 required to do that.

15 Q. So the change that we are talking
16 about is a requirement that anybody -- any
17 facility that wants to be a CCBHC has to
18 provide those services. Do you know whether
19 or not at least the five that you can recall
20 that are applying currently provide that
21 service?

22 A. I would say the majority do not
23 right now.

24 Q. And you expect that to be in effect

1 by the end of 2024?

2 A. Our state plan amendment is being
3 submitted to CMS this month. So depending
4 on CMS's approval date, yes, we are looking
5 at it by the end of 2024.

6 Q. And you brought a lot of documents
7 with you today.

8 MR. WALTERS: And this is really
9 a question for counsel. Are there any
10 documents in there that are not Bates
11 stamped?

12 MS. DOTY: There are three
13 documents that are not Bates stamped. But
14 we can produce those to you.

15 MR. WALTERS: What I would like
16 is -- because I don't -- obviously I don't
17 want more documents that I don't need --
18 yeah, a copy of the documents that are not
19 Bates stamped, the index.

20 Q. And the outline you are working off
21 of today, did you create that outline?

22 A. No, I did not.

23 MR. WALTERS: I want a copy of
24 the outline.

1 MS. DOTY: Okay.

2 MR. WALTERS: Give us just a
3 second. We are about done. But I need just
4 a short break.

5 (Break in proceedings from
6 10:12 to 10:14 a.m.)

7 BY MR. WALTERS:

8 Q. We have been talking about programs
9 that were provided by BBH that BMS is now
10 getting Medicare coverage -- Medicaid
11 coverage for. Are there any programs that
12 BBH is operating whose purpose -- or at
13 least part of the purpose is to prevent
14 children from going into residential
15 treatment that BMS is not trying to expand
16 Medicaid coverage for?

17 MS. DOTY: Objection. Outside
18 the scope.

19 A. Not at this time.

20 Q. You said you have been director of
21 BMS for four years?

22 A. Yes.

23 Q. When was the decision first made to
24 start -- to take -- to start considering the

1 idea of expanding Medicaid coverage to these
2 particular BBH programs?

3 A. Well, I have been 16 years total in
4 the department. Just four years as the
5 director.

6 Q. So even better?

7 A. So yeah. So really probably the
8 start of the conversations happened -- I
9 know in 2016 is when we first started
10 talking about like developing CSED for
11 example. And then 2018, I want to say was
12 really when BBH started out with like PBS --
13 started talking about PBS and Children's
14 Mobile Crisis.

15 So really that 2016, 2018 was like
16 the pre, pre-planning, I would call it. And
17 then of course during the pandemic, we were
18 trying to put services, you know, in place
19 for these things, making sure we have CMS
20 approval for payment and all of those
21 things. So 2016, 2018 was really
22 pre-planning.

23 Q. Okay. And is that when BBH started
24 the programs or when Medicaid started -- or

1 when BMS started looking at the programs
2 that BBH was already running?

3 A. So I couldn't give you the exact
4 dates of when they started. They had
5 conversations with us saying we are thinking
6 about developing Children's Mobile Crisis
7 and working with Concord University for PBS.
8 So they always give us preliminary
9 conversations of this is what we are
10 thinking of doing. And as they go along, we
11 meet with them to see how is it going.
12 Because, you know, you want to make sure
13 that it can be sustainable by Medicaid. We
14 don't want to start programs that we have to
15 stop.

16 Q. Right.

17 A. So that's why we have those
18 conversations.

19 Q. So I think I -- and let me ask you
20 this way because I think I understand now.
21 So it is not like BBH was running any of
22 these programs for 20 years and BMS came
23 along and said, Oh, that's a great program,
24 let us use it? It was when they started it,

1 you monitored it to see if it was
2 sustainable and then decided to expand it to
3 Medicaid?

4 A. We would meet with them usually --
5 sometimes once a month at least for an
6 update, how is it going, what are you
7 learning, what's working, what's not
8 working. And then we also of course educate
9 them on we think CMS would approve it if we
10 do try these things and do these things.
11 And so -- or you can show us data or
12 documentation of your pilot program and how
13 it is working. So that helps us build the
14 state plan amendment, as well as the policy.

15 Q. And again, there is no -- so there
16 is no certain -- there's no programs that
17 BBH is current in operating. Are there any
18 that are in the process of evaluating or
19 beginning or considering --

20 MS. DOTY: Objection. Outside
21 the scope.

22 Q. -- that would potentially apply to
23 children -- trying to keep them out of
24 residential treatment services?

1 MS. DOTY: Objection. Outside
2 of the scope.

3 A. Not at this moment.

4 MR. WALTERS: Nothing further.

5 MS. DOTY: Okay. I would like
6 to do a short cross, if that's fine?

7 MR. WALTERS: Sure. Absolutely.

8 EXAMINATION

9 BY MS. DOTY:

10 Q. Ms. Parsons, what is Aetna's role
11 for providing Medicaid-covered services to
12 foster children in West Virginia?

13 A. We have two different contracts of
14 managed care organizations. One is Mountain
15 Health Trust, and that is with all of our
16 managed care organizations, including
17 Unicare, the health plan, and Aetna. We
18 will have another one called Highmark this
19 coming year. Mountain Health Promise is the
20 contract with Aetna that is particular to
21 foster care and the CS&ED Waiver.

22 Q. When did the Mountain Health
23 Promise contract go into place?

24 A. In 2020.

1 Q. Could you please describe what the
2 reimbursement looks like for CCBHCs when
3 that program gets off the ground?

4 A. Of course. So CCBHCs -- again,
5 they are an identified provider type. And
6 that is built upon what's called a PPS rate.
7 So there are four options of PPS per state,
8 PPS1, 2, 3 and 4. However, the state law
9 that was passed for CCBHC required us to do
10 what's called a daily encounter, which would
11 be the PPS1 rate.

12 So the way I would explain it is,
13 CCBHCs would be FQHC like, and that they're
14 paid on a encounter rate basis. So if
15 someone comes into a CCBHC and they get a
16 service, they are paid an encounter no
17 matter what type of service that they do as
18 long as it is based within the encounter
19 rate method of methodology.

20 So let's say someone came in and
21 got therapy. They are paid the encounter
22 rate, not the fee for service rate that you
23 would typically get like at an LBHC.

24 Q. And what does PPS stand for?

1 A. Prospective payment system.

2 Q. What does FQHC stand for?

3 A. Federally Qualified Health Center.

4 Q. When you say an encounter rate,
5 does that mean whatever service is provided,
6 it all gets billed at like the per diem rate
7 if it is a per diem payment?

8 A. Yes. So there would be codes built
9 under that bundle of that encounter. So
10 whatever those codes are. There may be some
11 codes outside of it, some of them. But the
12 majority would be under that encounter rate.

13 Q. So does whatever code for the
14 particular service, like outpatient
15 therapy --

16 A. Uh-huh.

17 Q. -- it gets rolled up into the like
18 umbrella encounter rate? Is that how it
19 works?

20 A. That's correct.

21 Q. Has BMS done anything to increase
22 reimbursement rates for service providers
23 since 2020?

24 A. So -- yes. So during the actual

1 pandemic, we gave a 70 percent increase,
2 which was a temporary one during the
3 emergency pandemic order. And 85 percent of
4 the 70 percent rate was for direct care
5 service workers. So the providers had to
6 sign an attestation stating that we will
7 take 85 percent of that 70 percent increase
8 and ensure it goes to our workers. Because
9 we wanted to ensure it retained workforce
10 during COVID. Because a lot of them worked
11 in -- face-to-face with a lot of
12 individuals. And so we didn't want to lose
13 our current workforce during the pandemic.

14 After the pandemic order was over,
15 we did a permanent 5 percent rate increase
16 for all behavioral codes for LBHCs.

17 Q. Okay. Does DoHS have any plans
18 related to affordability of health records
19 for children in foster care?

20 A. Yes. That is actually -- so right
21 now we are working with Aetna, who again has
22 that contract. And what they are going to
23 develop is called -- it's kind of called an
24 electronic health record passport, or an

1 electronic -- a mobile electronic health
2 record.

3 So what that means is, is they are
4 going to develop that to have -- everyone to
5 have access to the same information that it
6 needs to have, whether -- it could be the
7 worker, the guardian, the providers, managed
8 care organization. And the reason to do
9 that is to ensure that everyone is on the
10 same page about the person's care and they
11 have access to all of the same information
12 at the right time.

13 Q. Has DoHS made any amendments or
14 changes to the CSED Waiver since 2020?

15 A. I think there was one update. But
16 we are currently in draft right now since
17 the 1915(c) Waiver is in with CMS for
18 approval for changes.

19 So let me look right here. Number
20 nine. I believe it was updated in '21.

21 Q. Okay. And do you know off the top
22 of your head what those changes were in
23 2021?

24 A. It was mostly just clarification of

1 policy information. So once you have a
2 policy out -- as providers ask questions, we
3 develop what's called FAQs - frequently
4 asked questions. And we take those FAQs and
5 put them in the next policy amendment to
6 make sure it is clarified for all providers.

7 Q. And then has DoHS made any changes
8 to the reimbursement methodology for CSED
9 Waiver providers recently?

10 A. We are working with CMS to have an
11 update to the payment methodology. We have
12 to have permission for that approval. That
13 approval, I think we just got Friday
14 actually. So it will be what's called a
15 PMPM, which that lessens the administrative
16 burden for CSED Waiver providers. And we
17 have had several providers tell us that
18 where they weren't doing CSED before, they
19 probably would now because that's an ease of
20 billing administration and time.

21 So we are going to put that into
22 effect. So that's why the policy is in
23 draft. We had to wait for CMS to approve
24 the 1915(c) Waiver application. And now

1 that they have, we will then change that
2 payment methodology in our systems.

3 Q. And what does PMPM stand for?

4 A. Per member per month.

5 Q. Can you explain how that works?

6 What does a provider do and how do they get
7 paid?

8 A. Sure. So there's a couple of ways
9 Medicaid can do it. We have PMPWs or PMPMs.
10 So PMPM is like we pay a set rate to the
11 provider for that person, and they do all of
12 the services for that calendar month. And
13 the reason the payment becomes together is
14 because actuaries look at other states and
15 they look at our current claim system and
16 they develop that rate.

17 So it is not exactly like an
18 encounter rate, but it is a set rate per
19 member per month. And the reason that is,
20 is because you may have some children that
21 need a lot of services in a month and some
22 that may need not as many services. So they
23 take that average. And it allows to free up
24 time for the providers, not to do so much

1 documentation or administration overload to
2 do the billing of individual codes.

3 MS. DOTY: Okay. I don't have
4 any further questions. Thank you.

5 MR. WALTERS: Unfortunately, I
6 do. But not many.

7 THE WITNESS: Okay.

8 RE-EXAMINATION

9 BY MR. WALTERS:

10 Q. You had mentioned the 85 percent
11 raise that direct care workers received
12 during the pandemic, correct?

13 A. Uh-huh.

14 Q. Yes? Sorry.

15 A. Yes. I'm sorry.

16 Q. You are all right.

17 A. I got a drink there.

18 Q. Whose idea was that?

19 A. Commissioner Bean really -- and
20 worked with -- and I think it was -- our
21 secretary and our deputy secretaries worked
22 together. I think all states at that time -
23 I will be honest -- were in panic mode. So
24 we were all talking together as well to

1 figure out what we needed to do. We knew
2 our biggest concern was workforce
3 retainment. And so that's why our
4 leadership came together and made that
5 decision. And we had CMS approval.

6 Q. And I think you indicated that the
7 providers were required to provide
8 85 percent of the moneys directly to the
9 direct care workers, correct?

10 A. That's correct. They had to sign
11 an attestation.

12 Q. And then it reduced to 5 percent
13 when the program ended?

14 MS. DOTY: Objection. Vague.

15 A. Once the ARPA dollars, is what it
16 was called, for the federal government
17 ended, we still felt like we needed to do an
18 increase for our providers. So we found
19 5 percent based on our budget.

20 Q. Was there any effort to track the
21 amount of direct care workers who quit when
22 their pay was reduced by 80 percent?

23 MS. DOTY: Objection. Outside
24 of the scope, and mischaracterizes --

1 Q. When their bonus or their
2 additional funding of 80 percent was reduced
3 to 5?

4 MS. DOTY: Objection.
5 Mischaracterizes testimony.

6 A. I do not know on that fiscal
7 policy.

8 Q. But you understand what I'm asking.
9 85 percent was given to direct care workers,
10 correct?

11 A. Uh-huh.

12 MS. DOTY: Objection.
13 Mischaracterizes testimony.

14 Q. Right?

15 A. 85 percent of the 70 percent
16 increase was required to go to direct care
17 service workers.

18 Q. And then when the ARPA program
19 ended, that 85 became a 5 percent permanent
20 raise?

21 MS. DOTY: Objection.
22 Mischaracterizes testimony.

23 A. It did become a 5 percent permanent
24 raise.

1 Q. And I think you said you don't
2 know. But was there any effort to determine
3 how many direct care workers left when that
4 85 percent was reduced to 5 percent?

5 MS. DOTY: Objection.
6 Mischaracterizes testimony.

7 A. I do not know.

8 MR. WALTERS: I have nothing
9 further.

10 MS. DOTY: We would like the
11 opportunity to have Ms. Parsons read and
12 sign the transcript before it is finalized.

13 (Deposition concluded at 10:27 a.m.)

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CERTIFICATE

I, Tara Arthur, Certified Stenotype Reporter and Notary Public, do hereby certify that the foregoing deposition of the above-named witness, was duly taken by me in machine shorthand, and that the same were accurately written out in full and reduced to computer transcription.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and furthermore, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

My commission expires April 16, 2027.



Tara Arthur
Certified Court Reporter/Notary Public

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